Linda L. Zeineh, M.D.
Board Certified Plastic Surgeon

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PATIENT & INSURANCE INFORMATION (CHILD)

First Name: _____ MI: _____ Last Name: _____ Birthdate: _____
Home Address: _____ City: _____ Zip: _____
Home Phone #: _____ Sex: _____ Social Security #: _____
Mother's Name: (first) _____ (last) _____ Occupation: _____
Employer (name & address): _____

_____

Birthdate: _____ Social Security #: _____ Driver's License#: _____
Father's Name: (first) _____ (last) _____ Occupation: _____
Employer (name & address): _____

_____

Birthdate: _____ Social Security #: _____ Driver's License#: _____
Who referred child to my office? (If a physician, include address & phone #): _____

_____

if no referral, how did you know about my office? _____
Close friend or relative (not living with child) (name, address & phone #): _____

_____

_____

PRIMARY INSURANCE CARRIER:

Company Name: _____
Claims Billing Address: _____
Subscriber (Insured): _____ Relationship to Patient: _____
Policy Holder (If Group): _____
Group or Policy #: _____ Certificate: _____

SECONDARY INSURANCE CARRIER:

Company Name: _____
Claims Billing Address: _____
Subscriber (Insured): _____ Relationship to Patient: _____
Policy Holder (If Group): _____
Group or Policy #: _____ Certificate: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Dr. Zeineh to release to my insurance carrier any and all information that might be required in order to evaluate my claim (or potential claim) for insurance benefits pertaining to myself and/or my dependent. I hereby authorize my insurance carrier to pay, and hereby assign directly to Dr. Zeineh any and all benefits otherwise payable to me for her services. I understand that I am financially responsible for all charges incurred over and above those benefits that may be paid directly to Dr. Zeineh by my insurance carrier. A copy of this assignment shall be considered as valid as the original.

Authorized signature _____ Date _____